

save the systems, the board documents revealed.

I think that that physical deterioration is the best visible manifestation of what is happening in general. When you talk about meltdown, look at the physical deterioration. I quote: Deterioration in the actual school buildings is occurring at a rate faster than we can save systems, the board documents reveal.

In recent years about half of public school students have completed high school in 4 years; 9 percent have graduated later, by the age of 21; and the rest have been lost completely. Is this an example, a model for where we dare go in terms of education in America?

I am using the New York City school system because it is an example of where our big cities are. Now, there was a lot of praise for Chicago, and Chicago was being used as some kind of magic model for the improvement of big-city school systems. Now, I understand the tests have shown that Chicago is again in serious trouble, that there has been a lot of hype and a lot of public relations, but underneath the improvements have been minimal, and the improvements have been minimal because, again, the opportunity-to-learn standards have not been addressed sufficiently.

They have not provided the kinds of quality facilities, trained teachers, adequate supplies and equipment, laboratories for science, library books and libraries. It is so simple, the opportunity-to-learn standards, but it is the area where nobody wants to engage in a discussion.

Yes, we have two new pieces of legislation, one in the Senate, one in the House, which are professing to be the last word on education reform. A lot of people are already applauding the legislation before it is finalized, and before the President signs it. It is not the final word, I hope. If that is the final word, we are in serious trouble.

□ 1930

The final word has to be dictated by the insistence of the American people out there, who have made education the number one priority for the last 5 or 6 years. When you ask the question, what should Federal dollars be used for, where is the most Federal assistance needed, education continues to score right up there with other concerns like crime and Medicare and Medicaid. Usually education is ahead of them all.

So the public is way ahead of the leadership. We must run to catch up with the leadership. What is happening right now gives us an opportunity to do that. As long as the bill is being held, as long as we do not go to conference, as long as we do not have a final signature by the President, then there is room for negotiation, as long as we are dealing with the appropriation process

and it is understood that the glaring inadequacy of the present education legislation is in the area of resources, there is not enough money being guaranteed.

Oh, yes, the money is authorized. There is a reasonable amount authorized. If you are going to double the title I funding from the present amount to \$17.2 billion in 5 years, that is a great increase. That is an increase worth voting for. But at the same time the authorizing legislation says we can do that, the appropriation and budget process says there is no money.

I started by saying we have had two great legislative developments up to now in this session of Congress. One was the passage of the tax legislation, and the other was the passage of education legislation by both Houses, although the education legislation is not complete.

They do relate to each other. The passage of the tax legislation has put us in a situation where, despite the fact we have authorized more money for education, and the other body, the Senate bill authorizes even more than the House bill, we cannot actually get the money and the resources unless there is a change in the appropriation process.

Somehow between now and the end of this session, more money has to be found in that budget; some new device has to be developed to increase the revenue; some changes have to be made, decreases in expenditures and other areas that are less important. Somehow we have to continue to press forward and make the case that brain power is the number one need for this Nation at this time. Brain power and the pools of people produced to qualify to run a more and more complex society are at the heart of where we are going. Nothing else is going to move forward unless we have the appropriate brain power. Therefore, brain power should be number one.

If budget cuts have to be made somewhere else, we should make those budget cuts, or if we have to find some new source of revenue dedicated to education, then that has to be the case. We must save our schools, not only in New York City, from a growing meltdown; but we must understand that the same process, the meltdown process, is occurring elsewhere, and only Federal funds can be utilized to stop it.

#### HMO REFORM

The SPEAKER pro tempore (Mr. LAHOOD). Under the Speaker's announced policy of January 3, 2001, the gentleman from Iowa (Mr. GANSKE) is recognized for 60 minutes as the designee of the majority leader.

Mr. GANSKE. Mr. Speaker, I especially want to thank you for the time that you are spending in the Chair tonight, as you have many evenings with

your spare time. The Members of this House of Representatives who come to the floor to give Special Orders are especially appreciative as, over the years, other Members have volunteered their time to sit in the Chair so that we could do our Special Orders.

This is the beginning of our July 4th recess, and I will try to be somewhat briefer than the hour time that I am allotted for this.

Well, we have had, Mr. Speaker, a great debate going on in the Senate this week on the Patients' Bill of Rights; and I have been watching this with great interest, because for the past 5 years I have been working on this issue, and I have been coming to the floor frequently, just about every week, in order to give a Special Order talk on the status of legislation to help protect patients from abuses by HMOs.

I am looking forward to the day when we pass a strong Patients' Bill of Rights piece of legislation on this floor to go along with what I think will be a strong Patients' Bill of Rights coming out of the Senate, that we marry those two bills together, that we add some important access provisions, such as an expansion of medical savings accounts, tax deductibility for the self-employed, and we move that down to the President's desk.

I strongly encourage the President to sign that, because there have been some significant compromises over the past few years on this legislation that I believe meet the President's principles, and yet retains principles that he enunciated during the Presidential campaign, such as allowing for important State laws on patient protection to continue to function, laws like those in Texas, which appear to be working pretty well.

Mr. Speaker, why are we continuing to talk about this? Well, we have had gridlock here in Washington for several years on this; and it has been a shame, because every day the HMOs make millions and millions of decisions that can significantly affect the well being of the patients they are supposed to be serving.

Remember a few years ago, there was a movie, "As Good as It Gets." It had Helen Hunt, who had a child with asthma, talking to a friend, Jack Nicholson, in the movie; and her little boy was being denied needed treatment for his asthma, which prompted Ms. Hunt to run a string of expletives together about that HMO. And I saw something I never saw happen before in a movie theater or seen since: I saw people stand up and clap in agreement with Ms. Hunt on that.

Then we saw a few years ago a large number of jokes and cartoons about HMOs. You do not see it so much any more because, you know what? Everybody knows that this is a problem. In order for something to be humorous, there needs to be some element of surprise. But it is not surprising anymore

that people have problems. You talk to your friends, family members, colleagues, and practically everyone can come up with a story about how an HMO has inappropriately denied treatment to a patient.

Remember the problem that we had a few years ago when one of the HMOs said, well, you know what? We do not think you need to stay in the hospital if you deliver a baby. Our plan guidelines say outpatient deliveries.

So you had this type of cartoon. The maternity hospital, drive-through window: "Now only 6-minute stays for new moms." The person at the window saying, "Congratulations. Would you like fries with that," as the mom holds a crying baby, and she looks more than a little frazzled.

Well, it was not so funny when you started to see headlines on major newspapers around the country, like this one from the New York Post which said "What his parents didn't know about HMOs may have killed this baby." Or this headline from the New York Post that says "HMO's cruel rules leave her dying for the doc she needs."

Some of these cartoons were pretty hard hitting, and I would say the humor was black humor at a minimum. Here was a cartoon about HMOs that appeared a couple of years ago: "Cuddly-care HMO. How can I help you?" This is an operator at the end of one of those 1-800 numbers. She is repeating what she is hearing on the telephone, and she says, "Oh, you are at the emergency room and your husband needs approval for treatment."

Then she repeats what the person is saying. "He is gasping, writhing, eyes rolled back in his head? That doesn't sound all that serious to me."

Over on there it says, "Clutching his throat, turning purple? Um-hum."

Then she says, "Well, do you have an inhaler?"

Then she says, "He is dead?"

And then she says, "Well, then he certainly doesn't need emergency treatment, does he?"

And finally the HMO reviewer says, "Gee, people are always trying to rip us off."

Well, that was not too funny to this young lady. She fell off a 40-foot cliff about 60 miles west of Washington, D.C. She broke her pelvis, her arm and had a concussion; nearly was dead. Fortunately, her boyfriend had a cellular phone. He phoned in the helicopter. They loaded her up, got her to the hospital, she was admitted through the emergency room, in the ICU on intravenous narcotics, and she got better.

But then do you know what the HMO did? They would not pay her bill. They said that she had not phoned ahead for prior authorization.

Does that strike you as a little funny? How was she supposed to know she was going to fall off a cliff and break her leg and have a concussion?

Was she supposed to be able to read the tea leaves?

Oh, and this was an issue. This was one of the first issues we talked about on HMOs. Back in 1995 I had a bill called the Patient Right to Know Act, because it became known that HMOs were requiring doctors to phone them in order to get permission to tell the patient about all of their medical treatments that might be possible. So you would have a situation, for instance, where a woman comes in to see a doctor; she has a lump in her breast. Before the doctor tells her her three options, he says, "Oh, excuse me," goes out in the hallway, gets on the phone and says, "HMO, can I tell this lady all about her treatment options?"

So here we have a doctor saying, "Your best option is cremation; \$359, fully covered." And the patient is saying, "This is one of those HMO gag rules, right?"

That HMO gag rule was not so funny to this woman. Her HMO tried to gag the doctors treating her. She needed treatment for breast cancer. She did not get it, and she died. And, do you know what? Under the current Federal law, if you receive your insurance from your employer and the HMO makes a decision like that, under Federal law, current Federal law, they are liable for nothing except the cost of care denied. And if the patient is dead, then they are not responsible for anything. Now this little girl and boy and the woman's husband, they do not have their mom, because of what that HMO did.

Here is another cartoon. The doctor is taking care of a patient on the operating table. The doctor says "scalpel." The HMO bean counter says "pocket knife." The doctor says "suture." The HMO bean counter says "band-aid." The doctor says, "Let's get him to intensive care." The HMO bean counter says, "Call a cab."

Let me tell you about a real case that was sort of a call-a-cab response. Down in Texas, after they passed the patient protection bill down in Texas, there was a fellow named Mr. Palosika. He was suicidal. He was in the hospital. His doctor thought he needed to stay in the hospital because, if he left, he might commit suicide. But the HMO said, no, we do not think he needs to stay in the hospital, and we are not going to pay for it. If he wants to stay, fine. The family can pay for it themselves.

Well, when an HMO says that to most families, they do not have the money to pay for it up front themselves, so they just took him home.

□ 1945

That night, Mr. Palosika drank half a gallon of antifreeze and committed suicide.

Now, under Federal law, that HMO was supposed to, if they disagreed with the treating doctor's advice, they were

supposed to go to an expedited, independent review panel, but they did not do that, they just ignored the law. And that is why it is very important when we are dealing with patient protection legislation that we have a strong enforcement mechanism; not to create new lawsuits, but to prevent those lawsuits by making sure that the HMOs know that they will be responsible at the end of the day so they do not make decisions or so that they do not follow the rules, or, I should say, in order to ensure that they do follow the rules.

Here is another one of those cartoons. This is the HMO claims department. The claims reviewer is saying, "No, we don't authorize that specialist; no, we don't cover that operation; no, we don't pay for that medication," and then apparently somebody says something to the operator, and she says, "No, we don't consider this assisted suicide."

Mr. Speaker, I hope I do not have to talk about this case much longer. I hope we really do pass a strong Patients' Bill of Rights soon, the Ganske-Dingell bill, on this floor. This is a little boy that I know. He is now about 8 years old, but when he was 6 months old, he had a fever of about 104, and he was sick one night, and his mom phoned the HMO, a 1-800 number, probably thousands of miles away, and said, my baby is sick, we need to go to the emergency room. And the medical reviewer said, well, under our contract, I will only authorize you to take little James to this one emergency room. That is all we have a contract with. Mom and Dad lived way on the outside of Atlanta, Georgia. Mom said, well, where is it? This voice over the phone said, I don't know, find a map. Made a medical decision, medical judgment, that reviewer did, that he was healthy enough to withstand a very long drive through Atlanta and bypass three hospitals with emergency rooms.

So Mom and Dad wrap him up. It is the middle of the night. They start their trek, they pass those emergency rooms where they could have stopped if they had authorization, but they were not health care professionals, they did not know how sick little James was, but he then suffered a cardiac arrest. Fortunately, they were able to keep him going until they pulled into the emergency room. Mom leaped out of the car screaming, save my baby, save my baby. A nurse ran out. She started an IV, they started mouth-to-mouth resuscitation, they gave him medicines, they saved his life, but they did not save all of this little boy. Because of that cardiac arrest, he ended up with gangrene in both hands and both feet, and, consequently, both hands and both feet had to be amputated.

Under current Federal law, an employer health plan that makes that kind of medical judgment that results in that kind of injury to this patient is

liable for nothing except the cost of his amputations.

I will tell my colleagues something. Once in a while I read an article, an editorial in a newspaper, and I hear opponents to our legislation saying, oh, those are just anecdotes. Those are just anecdotes. That girl that fell off the cliff, that was just an anecdote. The young mother who died because she did not get the care from the HMO, that is just an anecdote. A little boy who loses both hands and both feet, that is just an anecdote.

Mr. Speaker, do you know what I say to those people? I say, you know what? If this little anecdote had a finger, and if you pricked it, it would bleed. I say, this anecdote has to pull his leg prostheses with his arm stumps every day. This anecdote needs help putting on both bilateral prostheses. This anecdote will never be able to touch the face of the woman that he loves with his hand. He will never be able to play basketball. Now, he is a pretty well-adjusted kid, considering everything. He is a great kid. But I tell my colleagues, I want those people who write those op-ed pieces to meet this little anecdote and look him in the eye and tell him that we do not need a Patients' Bill of Rights.

I will tell my colleagues this: There are not just a few anecdotes around the country. I get phone calls and letters from people all over the country. Just recently in Des Moines, Iowa, a woman came up to me and she said, I tell you what. I am fed up with our HMO. I have breast cancer. I have been battling this for a while. The treatments have made me worn out. But my doctor told me that I needed a test to see if the cancer had come back, and the HMO would not authorize it. Other doctors said the same thing, that I needed the test. It did not matter. The HMO would not authorize it. Finally, after a long fight, they authorized it, and then the day I was supposed to get it, they said no.

And she said, Congressman, I went to my husband and I said to him, you know, Bill, I am going to ask you to do something I have never asked you to do for me before. That HMO has worn me out. I cannot fight them anymore. You are going to have to carry this for me. You are going to have to fight that HMO.

Mr. Speaker, there is a real need to pass this. People pay a lot of money and their employers contribute a lot of money for their health care. They work a lot of hours to earn that health care. When they finally get sick, it ought to mean something. They ought to be treated with justice and human compassion and not by green eyeshades looking at the bottom line and coming up with some arbitrary definition of medical necessity.

Mr. Speaker, under this Federal law I am talking about that passed 25 years ago, an employer health plan can de-

fine medical necessity as anything they want to. Some health plans have defined medical necessity as the cheapest, least expensive care, quote/unquote. Well, before coming to Congress, I was a reconstructive surgeon. I took care of children with cleft lips and palates. More than 50 percent of the surgeons in this country that do that kind of work in the last several years have had cases denied for kids with cleft lips and palates by the HMO saying, oh, that is not medically necessary. And under Federal law, they can define it any way they want.

That is why they had a big debate on this yesterday in the Senate, and they have managed to preserve language that says, if there is a dispute, an independent panel will make that decision and not be bound by the plan's arbitrary and unfair guidelines, so that if there is a denial of care, you get an honest-to-God chance that you will get the treatment you need.

I commend the Senators who voted to preserve that very, very important issue of letting an independent panel determine medical necessity and not be bound by a plan's guidelines. That does not mean that our law says, our bill says that employers cannot set up their own benefits package. We are very clear on that. We do not change that for ERISA at all. If an employer wants to purchase a plan where the plan says explicitly in the contract language, we do not provide heart-lung transplants, that is fine. It is not what I would recommend, but they can do that, and we do not change that. If a patient came along and needed that, then they would have to come up with that financing themselves because it has been made explicitly clear. But if it has not been made clear that that is an explicit exclusion, and if the patient does need that and believe that they would get that under that type of agreement, then they should, they should.

We say in our bill, the Ganske-Dingell bill, the Bipartisan Patient Protection Act of 2001, we say that businesses are protected from liability. We have a standard in our bill that says, businesses will not be liable unless they enter into direct participation in the HMO's decision that would result in injury. That is a standard that many of my Republican colleagues agreed with 2 years ago, and we adopted it.

I had a good friend who is a businessman from Des Moines, Iowa, phone me today, and he wanted to know whether he would be liable under our bill, and I said, how do you provide your health insurance for your employees? He said, well, we hire BlueCross BlueShield. We take one of their plans or another plan. I said, do you ever get involved in BlueCross BlueShield's decisions? He said, oh, no. Oh, no. That is a matter of personal privacy for our employees. We do not want to know what is happening

to their personal lives, and, quite frankly, they do not want us to know what is going on, and we do not want to know, if only for the reason that maybe we would have an employee at some time that is not performing up to par, and we might have to let that employee go, and we do not want that employee coming in and saying, well, you are just letting me go because you found out that I have diabetes or that I had to see a psychiatrist.

Under our bill, the Ganske-Dingell bill, employers are protected from liability, unless, unless they directly participate. Furthermore, there has been additional protective language now adopted on the Senate side on this issue, and we think that that is a positive. We just want to make sure, not that there will be a lawsuit at the end of the day, but that if there is a dispute on care where the HMO says no, but the patient's doctors say yes, that there is a mechanism for resolving that dispute before anyone is injured, if necessary, going to an independent panel whose decision would be binding on the health plan, an independent panel where the decision would be binding on the health plan.

In that circumstance, in the Ganske-Dingell bill, you know what? We give total punitive damages relief to the health plan. We say, if this dispute goes to an independent panel, and a health plan follows the decision, then they cannot be held liable at all for punitive damages. That has been one of the major concerns, large punitive damage awards by the business community.

Some people attack our bill by saying, oh, it is going to increase the costs for health insurance premiums. We hear that a lot in the debate that has been going on in the Senate. My answer to that is that the Congressional Budget Office has looked at our bill, the McCain-Edwards bill is the companion bill that is being debated in the Senate, they have looked at our bill and they say that the total cost would be 4 percent increase in premiums over 5 years, so less than 1 percent per year. The alternative, Frist-Breaux bill, the GOP bill in the Senate, would increase premiums by about 3 percent over the same period of time. But the provision on the liability would result in a total increase in premiums of only .8 percent over 5 years. That is less than two-tenths of a percent. The analysis of that would show in practical terms that the cost of our bill would be about the cost of a Big Mac meal per month per employee.

Mr. Speaker, the surveys around the country show that people think that that would be well worth it to know that they would be treated fairly.

Now, just this week there has been a big roll-out of an opposition bill to the Ganske-Dingell bill. It is called the Fletcher bill, the Fletcher-Thomas bill.

□ 2000

It is called the Fletcher bill, the Fletcher-Thomas bill. As a doctor, I know that you do not do a complete physical exam without examining the body under the clothing. So there were a lot of good words said by the opponents to our bill about the Fletcher bill, but I have looked at the body of that Fletcher bill.

I will tell my colleagues something, it is not pretty, except to the HMOs. When the Fletcher bill is stripped of its spin, the bones, and the sinews look like the old HMO protection bills that the opponents to real patient protection have tried to confuse the public with for several years.

For example, in the Fletcher bill, there are significant constraints on the independence of the medical reviewer. The standards of review would actually codify negligent health plan practices. It would make them unreviewable.

The Fletcher bill's designated decisionmaker language could be gamed by the HMO. They are working on designated decisionmaker language on the Senate side right now. Senator SNOWE is working on that, and there is a way to write that language that is fine, it adds language that is protective for employers, but at the same time prevents that language from being used to deny patients the care they need.

Mr. Speaker, I am very pleased to see progress being made on that on the Senate side. The Fletcher bill, despite the plan's sponsor's contentions, reverses State law. It effectively federalizes State law by saying that the only allowance for State court is if an HMO does not comply with the review panel, which under the Fletcher bill, the HMO is able to stack in its own favor. Those are just a few of the diseases on the Fletcher bill.

I advise my fellow Republican House Members to become aware of being infected with the Fletcher bill. The real cure is the Ganske-Dingell bill.

Here are some statements from my great colleague, the gentleman from Georgia (Mr. NORWOOD), who has worked with me and the gentleman from Michigan (Mr. DINGELL) hand in hand on this for years.

Here is what the gentleman from Georgia (Mr. NORWOOD), a very conservative Republican, says about the Fletcher bill. He says a patient could suffer injury or death from improperly denied care and still be blocked from a just court remedy with the Fletcher bill.

Here is what the gentleman from Georgia (Mr. NORWOOD) says about the Fletcher bill. The design of this latest imposter bill is identical to previous attempts to derail patients' rights, create a technical right to sue an HMO with conditions that will disqualify the majority of cases quote unquote.

The gentleman from Georgia goes on to say the HMO chooses the external

appeals panel, which then determines whether the patient can go to court and the patient has no right of appeal.

This alone is an insurmountable hurdle. It is just the tip of the iceberg. This bill, speaking about the Fletcher bill, imposes the responsibility of allowing a choice of the doctor on the employer instead of the HMO, and then it disqualifies the majority of employees from having the right to begin with. It contains nothing on adding prescription drug reform.

The list goes on and on so far, in fact, that patients would be better off with no bill than with the Fletcher bill, quote, unquote.

Mr. Speaker, my friend, the gentleman from Georgia, goes on in his press release and says the Fletcher bill further proposes that all suits over improperly denied care be removed to Federal court, with the exception of cases in which HMOs violate Federal law by refusing to comply with legally binding decisions of medical review panels.

If the injury or death of a patient occurred prior to the ruling or through the delay imposed by the ruling, the patient loses their legal rights under the Fletcher bill, even their current limited right to sue under State law gained through the recent fifth court decision, upholding a portion of the liability provisions in the Texas patient protection act.

The gentleman from Georgia continues in his press release, the new bill would accordingly preempt, preempt patient laws in Texas, Georgia, Arizona, California, Louisiana, Maine, Missouri, New Mexico, Oklahoma, Oregon, Washington, and West Virginia. Let me repeat that. My friend, the gentleman from Georgia, says the Fletcher bill would preempt patient protection laws in Texas, Georgia, Arizona, California, Louisiana, Maine, Missouri, New Mexico, Oklahoma, Oregon, Washington, and West Virginia.

Let us talk a little bit about the comparison of the Fletcher bill to the Ganske-Dingell-Norwood bill. Fletcher claims the plans face unlimited punitive damages in State court and \$5 million punitive damages in Federal court, regardless of compliance with review process under the Ganske-Dingell bill.

Here is the fact. Under my bill, State level punitive damages awards are prohibited entirely if the plan follows the external appeals process. In addition, 33 States currently cap punitive and noneconomic damages. The law that would be in effect would be the law in those States.

Punitive damages are banned entirely in Federal court cases while \$5 million in civil penalties are available in Federal court if the plan is proven by clear and convincing evidence to have acted in bad faith with flagrant disregard for the rights of the patients. That is what is in the Ganske-Dingell-Norwood bill.

Mr. Speaker, the opponents to our bill, the gentleman from Kentucky (Mr. FLETCHER) here, claims that our bill allows lawsuits, not only under ERISA, but also COBRA or HIPPA while the original Norwood-Dingell bill we debated a few years ago allowed ERISA cases only.

Here is the fact. The Ganske bill removes contractual disputes to Federal court. Why do we do that?

Number one, the Supreme Court has already said that is what should be done. We do it to preserve the ability of the Employee Retirement Income Security Acts uniform contract benefits. Our inclusion does not produce any additional causes of action under Ganske-Dingell. It does protect the ability of plans and employers to offer uniform health benefit plans Nationwide.

Let me repeat that. Our bill is not a bill that would prevent an employer who works in many States from devising his own uniform benefits health plan. That is the fact. Fletcher claims that the Ganske-Dingell-Norwood bill would allow patients to sue in both Federal and State courts for the same injury; that is not correct. Our bill, the Ganske-Dingell bill, assigns contract disputes to Federal court, medical disputes to State court, patients must specify the grounds of the dispute when they file. Under standard court procedure, suits cannot be filed in both courts over the same grounds.

Here is what the gentleman from Georgia (Mr. NORWOOD) said. The Fletcher bill appears designed for one goal, the confusion of the public and of Republican Members who want to vote for real patient protections.

The gentleman from Georgia (Mr. NORWOOD) goes on and says any Member who supports this package, i.e., the Fletcher bill, does so for the exclusive benefit of the HMO lobby, quote, unquote.

Let me give you five quick comparisons between the Ganske-Dingell bill and the Fletcher bill. Number one, the Ganske-Dingell bill enables every American to choose their own doctor. The Fletcher bill does not give Americans the right to choose the doctor and puts the requirement that employees get an option to choose their own doctor on the employer.

Number two, the Ganske-Dingell bill ensures a fair review process. The Fletcher bill allows health plans to choose the reviewer at external review.

Number three, the Fletcher bill forces the patient to get approval from an external reviewer before they can seek damages for injury in court. The Ganske-Dingell bill says that a reviewer's decision must be considered as evidence, but does not create an absolute bar from damages.

Number four, the Fletcher bill will preempt 12 State laws that have been passed that allows HMOs to be held liable in State courts. The Ganske-Dingell bill protects those State laws, and

that is exactly one of the principles that President Bush said was essential on HMO reform during the campaign.

Number five, the Ganske-Dingell bill allows cases regarding medical decisions to be heard in State courts. The Fletcher bill allows patients to go to State court when a plan does not follow external review and erroneously causes a medical decision. We call that breaking the law.

Further, the Fletcher bill allows the patient to forum shop, the Fletcher bill allows the patient to forum shop between Federal and State court, not the Ganske-Dingell bill.

These are some of the important differences that we are talking about between the Ganske-Dingell bill and the Fletcher bill.

That is why over 500 health groups, consumer groups, professional groups have endorsed the Ganske-Dingell bill and very few have said much about the Fletcher bill, other than that in some cases, in some parts of the language, maybe it is okay. But if you look at the overall bill, the real patient protection bill is the Ganske-Dingell bill.

Mr. Speaker, I believe, we will see this in large part passed with the McCain-Edwards-Kennedy bill, which is the companion bill to our bill. I think in large part, it will pass in the Senate. I think with a pretty big vote.

Mr. Speaker, I applaud the hard work of the Senators who have worked on that and have shown a real concern for patient protections. I believe that will give us a big boost as we move into debate here on the House floor.

I am appreciative of the work that Senators like MIKE DEWINE and OLYMPIA SNOWE, LINCOLN CHAFEE, and others, who have put into this bipartisan bill as the Senate debate has moved forward. Those changes, as far as I have seen so far, look very acceptable to the gentleman from Georgia (Mr. NORWOOD) and myself and the gentleman from Michigan (Mr. DINGELL).

In the Senate, it would have been nice if they had added the expansion of medical savings accounts and the 100 percent deductibility for the self-insured. That is in our House bill, but under the rules in the Constitution, those types of provisions have to originate in the House so they did not debate those or pass those; but I believe they have wide bipartisan support.

Mr. Speaker, I think it showed that the Democrats were willing to move to a compromise on this bill. It is no secret, a lot of Democratic Members are not real keen on medical savings accounts, but under the Ganske-Dingell bill we expand those medical savings accounts. That is part of the compromised process. That is how you get things done here in Washington.

I will tell you what, a purely partisan vote in this House will not pass. The Fletcher bill is a partisan bill. There is one Democrat that supports it, maybe

two, but what we have is a real core of Republicans who have been stalwarts for patient protection, who have withstood the blows of the \$150 million campaign by the HMOs in this country trying to beat them down.

□ 2015

They have shown independence and courage, and I salute them. I look forward to this debate when it comes to the House floor after the July 4th recess.

I know that the gentleman from Georgia (Mr. NORWOOD) is going to go off his diet and will eat a little bit of red meat steak before we hit the floor. I am looking forward to working with the gentleman from Michigan (Mr. DINGELL) as we work on this bill here on the floor.

I am convinced that, if the Members will truly look at the bills, look at the bones and the sinews and the muscles, not just the clothing and the nice words, they will see that there is a significant difference. They should listen to the American Medical Association, and they should look at all the other groups that have looked at these bills and have said in very strong words the real patient protection bill, the bill that will help prevent situations like happened to this poor little boy is the Ganske-Dingell bill.

I ask my colleagues over the July 4th recess to examine their consciences, to talk to some of the patients and the health care advocates and the health care professionals that have to deal with HMOs that make those types of arbitrary decisions that result in problems for patients.

Talk to them over the July 4th recess. Listen to them. They represent an awful lot of people in my colleagues' districts. I believe that if my colleagues do, they will come to the conclusion that it is time to get this off the congressional calendar. It is time to join the Senate, to pass a bipartisan and a bicameral bill.

Do not let it get hung up in committee, in a conference committee. Send it to the President's desk. I would love nothing better than for the President to look at the changes that we have done in the Senate debate and come to the conclusion that this bill, as I truly think it does, meets his principles and that he will sign it. That would be a very bright day for millions and millions of Americans.

#### SPECIAL ORDERS GRANTED

By unanimous consent, permission to address the House, following the legislative program and any special orders heretofore entered, was granted to:

(The following Members (at the request of Mr. McNULTY) to revise and extend their remarks and include extraneous material:)

Mr. DeFAZIO, for 5 minutes, today.

Ms. NORTON, for 5 minutes, today.

Mr. PALLONE, for 5 minutes, today.

(The following Members (at the request of Mrs. MORELLA) to revise and extend their remarks and include extraneous material:)

Mr. GUTKNECHT, for 5 minutes, today.

Mr. NUSSLE, for 5 minutes, today.

Mrs. MORELLA, for 5 minutes, today.

#### ADJOURNMENT TO TUESDAY, JULY 10, 2001

Mr. GANSKE. Mr. Speaker, pursuant to House Concurrent Resolution 176, I move that the House do now adjourn.

The SPEAKER pro tempore. Pursuant to House Concurrent Resolution 176 of the 107th Congress, the House stands adjourned until 2 p.m. on Tuesday, July 10, 2001.

Thereupon (at 8 o'clock and 19 minutes p.m.), pursuant to House Concurrent Resolution 176, the House adjourned until Tuesday, July 10, 2001, at 2 p.m.

#### EXECUTIVE COMMUNICATIONS, ETC.

Under clause 8 of rule XII, executive communications were taken from the Speaker's table and referred as follows:

2719. A communication from the President of the United States, transmitting requests for Fiscal Year 2002 budget amendments for the Department of Defense; (H. Doc. No. 107-92); to the Committee on Appropriations and ordered to be printed.

2720. A letter from the Legislative and Regulatory Activities Division, Office of the Comptroller of the Currency, transmitting the Office's final rule—Fiduciary Activities of National Banks [Docket No. 01-14] (RIN: 1557-AB79) received June 27, 2001, pursuant to 5 U.S.C. 801(a)(1)(A); to the Committee on Financial Services.

2721. A letter from the Legislative and Regulatory Activities Division, Office of the Comptroller of the Currency, transmitting the Office's final rule—Investment Securities; Bank Activities and Operations; Leasing [Docket No. 01-13] (RIN: 1557-AB94) received June 27, 2001, pursuant to 5 U.S.C. 801(a)(1)(A); to the Committee on Financial Services.

2722. A letter from the Deputy Assistant Secretary for Policy, Planning and Innovation, Department of Education, transmitting Final Regulations—Federal Work Study Programs, Federal Supplemental Educational Opportunity Grant Program, and Special Leveraging Educational Assistance Partnership Program, pursuant to 20 U.S.C. 1232(f); to the Committee on Education and the Workforce.

2723. A letter from the Principal Deputy Associate Administrator, Environmental Protection Agency, transmitting the Agency's final rule—OMB Approvals Under the Paperwork Reduction Act; Technical Amendment [OPPTS-00310; FRL-6771-7] received June 27, 2001, pursuant to 5 U.S.C. 801(a)(1)(A); to the Committee on Energy and Commerce.

2724. A letter from the Principal Deputy Associate Administrator, Environmental Protection Agency, transmitting the Agency's final rule—Approval of section 112(1) Authority for Hazardous Air Pollutants; Chemical Accident Prevention Provisions; Risk